Office of Public Instruction
Linda McCulloch, Superintendent
PO Box 202501
Helena, MT 59620-2501

Child Study Team Report

STUDENT INFORMATION

Students Name	Initials	Birthdate	Age	Gender M F	Grade	Today's Date

District/School	Initial Referral Date	Initial Evaluation ☐
	Next Comprehensive Reevaluation Due	Reevaluation ☐
Parent(s) Name	Parent(s) Address	Home Phone
	E-mail	Work Phone/Cell Phone

EVALUATIONS AND INFORMATION PROVIDED BY THE PARENT(S) AND/OR STUDENT

Parent Comments*:_____

Student Comments:_____

Implications/Instructional Strategies for Educational Planning:_____

ASSESSMENT AREAS

Assessment results, including implications for educational planning, may be summarized or attached as written reports.

Summarized	Attached		Summarized	Attached	
☐	☐	Academic Achievement	☐	☐	Observations*
☐	☐	Assistive Technology/Services	☐	☐	Physical
☐	☐	Behavioral	☐	☐	Psychological
☐	☐	Classroom-Based Assessment*	☐	☐	Social/Emotional
☐	☐	Communication	☐	☐	Transition
☐	☐	Developmental	☐	☐	Other:_____
☐	☐	Functional Behavior Assessment			

* Required

Student Name:_____ **CST Date:**_____

ASSESSMENT SUMMARIES

Assessment Area:_____ Evaluator(s):_____ Date of Eval/Observ:_____

Results: _____

Implications for Educational Planning: _____

Assessment Area:_____ Evaluator(s):_____ Date of Eval/Observ:_____

Results: _____

Implications for Educational Planning: _____

Assessment Area:_____ Evaluator(s):_____ Date of Eval/Observ:_____

Results: _____

Implications for Educational Planning: _____

Student Name:_____ **CST Date:**_____

ASSESSMENT SUMMARIES

Assessment Area:_____ Evaluator(s):_____ Date of Eval/Observ:_____

Results: _____

Implications for Educational Planning: _____

Assessment Area:_____ Evaluator(s):_____ Date of Eval/Observ:_____

Results: _____

Implications for Educational Planning: _____

Assessment Area:_____ Evaluator(s):_____ Date of Eval/Observ:_____

Results: _____

Implications for Educational Planning: _____

Student Name: _____ **CST Date:** _____

ELIGIBILITY DETERMINATION

Student **IS** eligible for special education and related services under the Individuals with Disabilities Education Act. Basis for making the determination that the student has a disability and needs special education and related services:

Disability criteria: _____

_____

_____

☐ Criteria Checklist Attached

Why does the student need special education and related services? _____

_____

_____

_____

Disability Categories (check all that apply):

☐ Autism	☐ Deafness	☐ Other Health Impairment
☐ Developmental Delay	☐ Emotional Disturbance	☐ Specific Learning Disability
☐ Cognitive Delay	☐ Hearing Impairment	☐ Speech Language Impairment
☐ Deaf-Blindness	☐ Orthopedic Impairment	☐ Traumatic Brain Injury
		☐ Visual Impairment

Recommendations for consideration by the IEP team:

Special Education Services

☐ Adaptive Physical Education	☐ Reading	☐ Speech/Language
☐ Braille Instruction	☐ Self-Help/Independence	☐ Transition
☐ Career/Vocational	☐ Sensory-Motor	☐ Travel Training
☐ Communication	☐ Social/Emotional/Behavioral	☐ Written Expression
☐ Math		

Related Services

☐ Assistive Technology	☐ Parent Counseling and Training	☐ Social Work in Schools
☐ Audiology	☐ Physical Therapy	☐ Speech/Language
☐ Counseling	☐ Psychological	☐ Therapeutic Recreation
☐ Medical (diagnostic)	☐ Recreation	☐ Transportation
☐ Occupational Therapy	☐ Rehabilitation Counseling	☐ Other: _____
☐ Orientation and Mobility	☐ School Health	

DOCUMENTATION—if not eligible

Student **IS NOT** eligible for special education and related services under the Individuals with Disabilities Education Act for the following reason(s):

☐ Does not meet disability criteria
☐ Does not demonstrate need for special education
☐ Lack of instruction in reading or math
☐ Limited English proficiency

Discussion: _____

_____

Recommendation for accommodation or referral for other services as appropriate: _____

Student Name:_____ **CST Date:**_____

The following persons, as indicated by their signatures, have participated in the development of this CST document. The public agency shall give the parent a copy of the child's CST at no cost to the parent.

Parent	Date	**Parent**	Date
Student	Date	**Speech/Language Pathologist**	Date
Administrator or Designee	Date	**Signature/Position**	Date
General Education Teacher	Date	**Signature/Position**	Date
Special Education Teacher	Date	**Signature/Position**	Date
School Psychologist	Date	**Signature/Position**	Date

Each participant of the Child Study Team shall be provided an opportunity to submit a separate statement of conclusions if the report does not reflect the conclusions of the participant. ☐ Dissenting report will be attached.

Person(s) submitting a separate statement of conclusions: _____

Reasons: _____

_____

_____

CST MINUTES

CST MINUTES